



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AVEEWAN YUN, D.O.
PO BOX 121589
ARLINGTON, TEXAS 76012

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-3392-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "NOT PAID PER THE DWC FEE GUIDELINES"

Amount in Dispute: \$230.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on March 30, 2011 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2009	99456-W5-26 and 99456-W5-TC	\$230.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 03, 2009

- W1 – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated December 03, 2009

- W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The provider billed the amount of \$650.00 for CPT code 99456-W5-26 for the professional component and \$650 for CPT code 99456-W5-TC for the technical component of Maximum Medical Improvement/Impairment Rating (MMI/IR) as a DD. Documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. 28 Texas Administrative Code §134.204 states in parts (j)(4)(C)(iv) and (v):

(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

(v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

2. The total MAR for the MMI/IR examination is \$350.00 because documentation does not support that any IR was performed. The documentation states that "Range of motion of the left arm could not be measured in order to determine an impairment rating" and "no diagnosis related impairment for the left arm that would be ratable" as well as injured worker "is assigned **No Permanent Impairment.**" The employee does not have any permanent impairment as a result of the compensable injury. Requestor has been reimbursed \$350.00 on the 99456-W5-26 coding and \$70.00 for 99456-W5-TC coding. The requestor has been reimbursed \$420.00 for a service that has a MAR of \$350.00 between both CPT codes. There is no recommendation for additional payment as there was no impairment rated.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature



Signature

Gregory Fournerat

Medical Fee Dispute Resolution Officer

November 10, 2011

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

